**U.S. Department of Labor**

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

**Issue Date: 31 July 2006**

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In the Matter of:

DORIS VANDALL,
On Behalf of AMOS VANDALL,
Claimant

v.

SEWELL COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No.: 2004-BLA-64

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Appearances:

James M. Phemister
Legal Practice Clinic
Washington and Lee University
Lexington, Virginia
For the Claimant

Ashley M. Harman, Esq.
Douglas A. Smoot, Esq.
Jackson & Kelly, PLLC
Morgantown, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

## DECISION AND ORDER GRANTING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death

was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant alleges that the Miner was totally disabled by pneumoconiosis.

This claim was heard consecutively with a claim filed by the Claimant on her own behalf as the survivor of a miner who died due to coal workers' pneumoconiosis. Because the claims were filed at different times, different versions of the regulations apply. In particular, the evidentiary limitations found in the current rules at 20 CFR § 725.414 (2005) are applicable to the survivor's claim, but not to the miner's claim. For this reason, I held separate hearings for the two claims (*see* the "Order Clarifying Notice of Hearing and Prehearing Order issued June 23, 2004, and the Transcript ("Tr.") at 5-18), and I have written separate decisions for the two claims.

The caption for this claim has been changed. At the hearing, counsel for the Employer advised that Acordia Employer Service, a third-party administrator, had been erroneously named in the caption as an insurance carrier. The Employer, Sewell Coal Company, is a wholly owned subsidiary of Pittston Coal Group, and self-insured. Tr. at 20. In accordance with my ruling at the hearing, Acordia Employer Service has been removed from the caption.

I conducted a hearing on the Miner's claim on August 10, 2004, in Beckley, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). No witnesses testified at the hearing on the Miner's claim. Tr. at 35-36. Director's Exhibits ("DX") 1-129 (except for DX 83, which related to another miner and was in the file due to an error)[1], 137-139, 151-152, and 154-156, Claimant's Exhibits ("CX") 1-2, and Employer's Exhibits ("EX") 1-11 were admitted into evidence without objection, subject to the Claimant's right to provide rebuttal to EX 8, 9, and 10, which were submitted less than 20 days in advance of the hearing. Tr. at 19-31. The record was held open after the hearing to allow the parties to submit additional evidence and closing arguments. No further evidence was submitted. The parties submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into the record of the Miner's claim, and the arguments of the parties.

## PROCEDURAL HISTORY

Mr. Vandall filed his initial claim on August 7, 1972. DX 70-1. The claim was denied by the Social Security Administration on July 30, 1973, on the grounds that the evidence did not show that the Miner had pneumoconiosis, or that the Miner was totally disabled due to pneumoconiosis. DX 70-8, 9. The claim was reconsidered and denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on October 24, 1980, on the grounds

[1] After the hearing, I discovered that a similar error occurred with respect to DX 71-42. That exhibit has also been removed from the file because it did not pertain to Mr. Vandall.

that the evidence did not show that the Claimant was totally disabled due to pneumoconiosis. DX 70-21; DX 71-27 – 71-32. The Claimant did not appeal that determination.

More than one year later, on December 2, 1985, Mr. Vandall filed a duplicate claim. DX 71-1. The claim was finally denied by Administrative Law Judge Rippey on August 3, 1990, who found that the Claimant had failed to prove that there had been a change in conditions since the previous claim was denied, or that he had pneumoconiosis. DX 71-54.

Next, on July 22, 1992, more than one year later, Mr. Vandall filed another duplicate claim. DX 4. On September 23, 1994, Administrative Law Judge Neal issued a Decision and Order denying benefits, finding that the evidence did not show that Mr. Vandall suffered from pneumoconiosis. DX 49. Mr. Vandall appealed this decision on September 30, 1994. DX 50. The Benefits Review Board (the "BRB") affirmed Judge Neal's denial of benefits on August 23, 1995. DX 57. Upon Mr. Vandall's motion for reconsideration, the BRB remanded the case on January 9, 1997. DX 61. Upon remand, Judge Neal issued a Decision and Order denying benefits, finding no pneumoconiosis or total disability due to pneumoconiosis. DX 62. Mr. Vandall initially appealed this decision on July 6, 1998. DX 63; DX 68. On November 24, 1998, Mr. Vandall filed for modification. DX 63; DX 67; DX 72. The Board dismissed the appeal and remanded the case to the District Director, who denied the request for modification on May 6, 1999. DX 69; DX 76. The Miner requested a hearing on May 17, 1999. DX 77. Administrative Law Judge Lesnick presided over the hearing in Beckley, West Virginia, on January 27, 2000. DX 106. On August 7, 2000, Judge Lesnick issued a Decision and Order Denying Benefits. Judge Lesnick found that Mr. Vandall did not prove that he suffered from pneumoconiosis or that he was totally disabled due to pneumoconiosis. DX 114.

On September 2, 2000, Mr. Vandall appealed Judge Lesnick's Decision and Order. DX 117. On September 25, 2000, the Board acknowledged Mr. Vandall's appeal and placed it on the docket. DX 118. Mr. Vandall passed away on January 4, 2001. On April 10, 2001, Mrs. Vandall requested modification of his claim. DX 121. The Benefits Review Board dismissed the appeal and remanded the case to the District Director. DX 122. On September 15, 2003, the District Director notified Mrs. Vandall that the request for modification would be referred to the Office of Administrative Law Judges and considered based upon an allegation that a mistake in fact was made in the prior denial since no new evidence was submitted within the allowed time period of 30 days. DX 129.

## APPLICABLE STANDARDS

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on July 22, 1992. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2005). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920, *et seq.* (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19,

2001. 20 CFR § 718.101(b) (2005). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do not apply to pending cases, see 20 CFR § 725.2(c) (2005). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2, and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930, *et seq.* (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the Court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2005 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that the miner was entitled to benefits in connection with his current claim, the Claimant must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he met the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffered from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis was totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2005). I must consider all of the evidence pertaining to this claim to determine whether there has been a change in conditions or a mistake of fact by ALJ Lesnick; new evidence is not required for me to reach a determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

Because the underlying claim is a duplicate claim, in order to be entitled to benefits, the Claimant must also establish a material change in conditions since the miner's previous claim was denied. 20 CFR § 725.309(d) (2000). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he was entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1362-1363 (4th Cir. 1996).

For the reasons explained below, I have found that the Claimant has established that Mr. Vandall had pneumoconiosis by means of autopsy evidence. It follows that there was a mistake of fact in denying the current claim, and that there has been a change in conditions since denial of the previous claim. Therefore, I must address all of the medical evidence from the current and previous claim in this decision.

## ISSUES

The issues contested by the Employer and the Director are:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he was totally disabled.

4. Whether his disability was due to pneumoconiosis.

5. Whether the evidence establishes a material change in conditions since denial of the previous claim pursuant to 20 CFR § 725.309 (2000).

6. Whether the evidence establishes a change in conditions or a mistake in a determination of fact in a prior denial of the current claim pursuant to 20 CFR § 725.310 (2000).

The Employer also reserved its right to challenge the statute and regulations. Whether the Miner was totally disabled was listed as an issue on the CM-1025, but the Employer stipulated that he was at the hearing before Judge Neal. DX 106, 145, 152; Tr. at 19.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Factual Background and the Claimant's Testimony

Mrs. Vandall did not testify at the August 10, 2004, hearing, but she testified at the previous hearing on the Miner's claim on January 27, 2000, DX 106. She was married to Mr. Vandall for 45 years. *See* DX 9, 136. Mrs. Vandall testified that Mr. Vandall smoked from 1952 to 1958. At the prior hearing, the parties stipulated that Mr. Vandall was totally disabled by a respiratory impairment. DX 106 at 7. At the time of the January 2000 hearing, Mr. Vandall was under the care of Dr. Rasmussen and had been for five years. Mr. Vandall had been on supplemental oxygen for three years and was on it 24 hours a day.

Mr. Vandall had testified at an earlier hearing held in Charleston, West Virginia, on March 14, 1994. DX 45A. At the time of that hearing, he was 61 years old and claimed Mrs. Vandall as his only dependent. Mr. Vandall had a 5th or 6th grade education. He testified that he had worked in the coal mines from 1945 and quit in 1982. The parties agreed that he had 30 years of coal mine employment. DX 152. Judges Neal and Lesnick found at least 20 years. Based on the record as a whole, *see also* DX 132-135, I find that he had at least 25 years of coal mine employment. His last employer was Sewell Coal Company in West Virginia. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). Mr. Vandall's first job in the coal mine was loading coal by hand, and then he moved to general inside labor.

Mr. Vandall also testified about his smoking history. He said he smoked while he was in the Army, beginning in 1952, until 1958, at a rate of one half pack of cigarettes per day. He said it was so dusty in the mines, he chewed tobacco to keep the dust down, but he denied smoking for as long as 22 years as alleged by Dr. Zaldivar. DX 45A at 23-24. In addition to his and his

wife's testimony at the hearings, Mr. Vandall reported a similar smoking history to his treating physicians. Although there was an occasional discrepancy in the reported years he started or stopped smoking, the weight of the most reliable evidence, his treatment records, bolstered by consistent testimony, supports the conclusion that Mr. Vandall had at most only a 3.5 to 7 pack-year smoking history.

Mr. Vandall died on January 4, 2001. The Death Certificate, signed by Dr. S.L. Bembalker, listed cardiorespiratory arrest as the immediate cause of Mr. Vandall's death. DX 137. Additionally, it listed coal workers' pneumoconiosis, COPD [chronic obstructive pulmonary disease] and ASHD [arteriosclerotic heart disease] as "other significant conditions contributing to death but not resulting in the underlying cause given …"

## Medical Evidence

### Medical Opinions

Medical opinions are relevant to the issues of whether the Miner had pneumoconiosis, whether the Miner was totally disabled, and whether pneumoconiosis caused the Miner's disability. The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204 (c)(2) (2005). The record contains the following medical opinions relating to the Miner's claim.

#### Treatment Records

##### Dr. Diaz

Dr. Clemente Diaz' treatment records from April 11, 1986, to September 28, 1989, are in the record. DX 97. It appears that Dr. Diaz began treating Mr. Vandall after he conducted an examination on behalf of the Department of Labor in March 1986 in connection with Mr. Vandall's second black lung claim. DX 71-19. A description of that examination appears below. The entry for April 11, 1986, notes, "spot in lungs poss[ible] granuloma found in Black lung examination." On June 18, 1986, diagnoses included coronary artery disease, COPD, pneumoconiosis, and "granuloma or tumor r[igh]t lung?"

##### Southern West Virginia Clinic

Mr. Vandall was seen by several doctors at the Southern West Virginia Clinic between 1987 and 1999. Dr. Diaz referred Mr. Vandall to Dr. James R. Wheeler for evaluation of black lung and heart trouble. DX 96. Dr. Wheeler examined Mr. Vandall on May 4, 1987. He noted Mr. Vandall's medical history, noting in particular problems of COPD, mild bronchitis, emphysema, and pneumoconiosis. Dr. Wheeler described him as a nonsmoker. Mr. Vandall was hospitalized for hypoglycemia in 1991. DX 21.

Dr. D.L. Rasmussen's treatment notes from the Southern West Virginia Clinic, from September 28, 1992, to October 21, 1999, are also in the record. DX 96. Dr. Rasmussen performed the examination of Mr. Vandall on behalf of the Department of Labor in August 1992, in connection with the claim underlying this request for modification. That examination, described in more detail below, revealed a significant pulmonary impairment. Chest examinations at the initial and subsequent examinations generally revealed markedly reduced breath sounds but no rales, rhonchi, or wheezes. Dr. Rasmussen opined that Mr. Vandall suffered from a severe pulmonary impairment, coal workers' pneumoconiosis (based upon x-rays), pulmonary emphysema, COPD with emphysema, and cor pulmonale. He also said there may be a component of asthma, but that was not his main problem. He also suspected arteriosclerotic heart disease.

In October 1993, Dr. T.A. Barghouthi administered a stress test which resulted in borderline ischemic changes, and ordered an echocardiogram. After the echocardiogram, Dr. Barghouthi decided that Mr. Vandall's chest pain was probably related to his chronic lung disease.

Detailed histories taken by Dr. Rasmussen in December 1993, and again in December 1995 and January 1998, reflected that Mr. Vandall smoked from 1951 to 1958, and never since. Repeat spirometry and diffusing capacity in January 1994 showed severe irreversible obstructive impairment, with maximum breathing capacity markedly reduced, and single breath carbon dioxide diffusing capacity moderately reduced, with the impairment slightly greater than previous studies.

Mr. Vandall was seen by Dr. S. Bembalker when he experienced an upper respiratory infection in April 1995, when Dr. Rasmussen was not available.

Repeat spirometry, diffusing capacity, resting blood gases, and lung capacity testing in February 1996 led to a characterization that Mr. Vandall was "severely incapacitated." A July 1996 exercise studied showed marked hypoxia with slight effort, though resting blood gases remained normal. The records reflect frequent complaints of worsening shortness of breath. Continuous oxygen was prescribed in March 1997. In March 1998, spirometry was slightly improved, but he had significant hypoxia. In June 1999, pulmonary function revealed very severe slightly reversible obstructive insufficiency, very marked reduction in single breath diffusing capacity, and marked hypoxia. At his last visit to Dr. Rasmussen in October 1999, Mr. Vandall had recently been released from a hospitalization for an acute exacerbation of his respiratory condition.

Appalachian Regional Hospital

Mr. Vandall was admitted into Appalachian Regional Hospital twice in October 1999. The first time he was admitted on October 1, 1999, and discharged on October 8, 1999. DX 96. Dr. Maiolo was Mr. Vandall's attending physician. Dr. Maiolo's discharge diagnoses included bronchopneumonia, COPD with acute respiratory distress, chronic hypoxemia, and chronic cor pulmonale with pulmonary hypertension.

The next time Mr. Vandall was admitted to Appalachian Regional Hospital was on October 26, 1999. DX 96. Dr. Bembalker was Mr. Vandall's attending physician. He remained in the hospital until November 4, 1999, and upon discharge was diagnosed by Dr. Bembalker with pneumonia, COPD, acute and chronic bronchitis, hypoxia, cor pulmonale, coal workers' pneumoconiosis, and pulmonary fibrosis.

The 1999 hospital records are the most recent available treatment records. As noted above, Mr. Vandall died in 2001. The records from Mr. Vandall's last illness are not in the file. According to the clinical summary prepared as part of an autopsy (DX 139), Mr. Vandall was admitted to the hospital on December 27, 2000, because of carbon dioxide narcosis. He was comatose, and intubated in the emergency room, after which he improved. He was extubated on December 28, but intubated again on December 30, requiring mechanical ventilation. He went into asystole on January 4, 2001, was resuscitated, but could not be revived. A chest autopsy was requested by the family to determine whether he had black lung disease. The results of the autopsy are described below.

Pathologists' Opinions Based Upon Autopsy

An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2005). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. Greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides. *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir. 1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197, 200 (3d Cir. 1982); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991); *Similia v. Bethlehem Mines Corp*., 7 B.L.R.1-535, 1-539 (1984); *Cantrell v. U.S. Steel Corp*., 6 B.L.R. 1-1003, 1-1006 (1984).

Dr. Quadri

Dr. S. Fiaz Quadri performed an autopsy of Mr. Vandall's lungs and heart on January 4, 2001. DX 139. He reviewed Mr. Vandall's clinical history and noted his history of "severe end-stage chronic obstructive pulmonary disease, severe respiratory insufficiency, and hypoxia." Additionally, Dr. Quadri noted that Mr. Vandall had a 26-year coal mine employment history. Dr. Quadri's macroscopic description of Mr. Vandall's lung stated that "the pleural surfaces were gray black with evidence of bullous emphysema at the apex of both the lungs." Additionally, he noted that "[t]he lung parenchyma reveals diffuse macular anthracotic pigmentation in both lungs . . . ." Dr. Quadri also noted that "[s]mall coal dust nodules are also identified in both the lungs . . . ." He noted that there was no evidence of complicated coal workers' pneumoconiosis. Next, Dr. Quadri went on to summarize his microscopic findings from sections taken from both of Mr. Vandall's lungs. He noted that coal dust macules were identified in multiple areas "consisting of accumulation of filled macrophages in the interstitium surrounded by focal areas of mild fibrosis. Coal dust nodules are also identified containing a central area of hylanized irregular collagen bands surrounded by pigment laden macrophages.

There is no evidence of complicated coal workers' pneumoconiosis. Emphysematous changes are identified in both the lungs." Lastly, Dr. Quadri found that sections taken from the right upper lobe of Mr. Vandall's lung revealed "a healed granuloma surrounded by areas of fibrosis and anthracotic pigmentation."

Dr. Perper

Dr. Joshua A. Perper reviewed Mr. Vandall's medical records on behalf of the Claimant, and provided a report dated November 22, 2002. CX 2. Dr. Perper is Board-certified in Anatomical and Surgical Pathology and Forensic Pathology. Dr. Perper reported that Mr. Vandall worked in the coal mines for at least 20 years, and stopped smoking in 1958. Dr. Perper opined that Mr. Vandall had pneumoconiosis. He based his diagnosis on the pathology report, coal mine employment, lack of significant smoking history, pulmonary function studies, and microscopic examination of lung autopsy section slides. He also found that the pulmonary function studies demonstrated that Mr. Vandall had "progressive obstructive pulmonary impairment and increasingly severe hypoxemia." Furthermore, Dr. Perper opined that coal workers' pneumoconiosis caused, substantially contributed to, or accelerated Mr. Vandall's death. Dr. Perper reviewed and criticized the reports of each of the Pathologists and other physicians who gave opinions on behalf of the Employer.

Dr. Tomashefski

Dr. Joseph F. Tomashefski, Jr., reviewed Mr. Vandall's medical records on behalf of the Employer, and provided a report dated April 5, 2002. EX 3; DX 138. Dr. Tomashefski is Board-certified in Anatomic and Clinical Pathology. Based upon his review of the medical records, the autopsy report and the slides of Mr. Vandall's lungs, Dr. Tomashefski opined that Mr. Vandall suffered from a moderate to severe mixed panacinar and centriacinar emphysema. He said that respiratory failure due to emphysema and asthma caused Mr. Vandall's death. Additionally, he opined that Mr. Vandall did not suffer from cor pulmonale. Overall, Dr. Tomashefski opined that Mr. Vandall suffered from mild simple coal workers' pneumoconiosis with mild simple silicosis. Additionally, he opined that these conditions would not have caused "Mr. Vandall any respiratory symptoms or significant respiratory impairment, and would not have contributed to the development of pulmonary hypertension or right ventricular hypertrophy." He went on to opine that Mr. Vandall was totally disabled "by the conditions of pulmonary emphysema and chronic asthma," and that "his mild simple coal workers' pneumoconiosis played no role in his disability or in his death." He said coal dust exposure is not a cause of emphysema, so he could only conclude that Mr. Vandall's emphysema was caused by exposure to tobacco smoke. On January 31, 2003, Dr. Tomashefski provided another report, which reviewed Dr. Perper's medical report. EX 3. Based upon this, Dr. Tomashefski summarized that he disagreed with Dr. Perper's basic conclusions and remained of the opinion that Mr. Vandall was "disabled from a respiratory standpoint by chronic asthma and emphysema, which represent the underlying cause of Mr. Vandall's death." In a deposition taken on August 3, 2004, Dr. Tomashefski testified regarding his review of Mr. Vandall's medical data. EX 11. Dr. Tomashefski reiterated the opinion he gave in his reports.

Dr. Oesterling

Dr. Everett F. Oesterling reviewed the Mr. Vandall's medical data and slides prepared of his lungs on behalf of the Employer, and prepared a report dated May 8, 2002. EX 4. Dr. Oesterling is Board-certified in Anatomical Pathology, Clinical Pathology, and Nuclear Medicine. Based upon his review of the records and slides, Dr. Oesterling opined that Mr. Vandall suffered from coal workers' pneumoconiosis, but this condition was not severe enough to interfere with pulmonary function or cause death. Dr. Oesterling opined that Mr. Vandall suffered from bronchial asthma, pulmonary emphysema, and atelectasis. He noted that these pulmonary conditions are unrelated to coal dust exposure. Dr. Oesterling prepared a supplementary report based upon Dr. Koenig's report dated July 27, 2004. EX 9. Dr. Oesterling opined that Dr. Koenig's opinion should be given little credence because of Dr. Koenig's inaccurate diagnosis of Mr. Vandall's condition.

Dr. Caffrey

Dr. P. Raphael Caffrey also provided a consultation report reviewing the autopsy section slides and Mr. Vandall's medical data on behalf of the Employer. EX 1. Dr. Caffrey is Board-certified in Anatomical Pathology and Clinical Pathology. Based upon his review of the microscopic slides, Dr. Caffrey opined that Mr. Vandall suffered from mild simple coal workers' pneumoconiosis, mild to moderate centrilobular emphysema, and mild chronic bronchitis. Upon review of the medical data, Dr. Caffrey opined that Mr. Vandall suffered from a mild degree of simple CWP, centrilobular or centriacinar emphysema, chronic bronchitis, bronchial asthma, and severe atherosclerosis of proximal aorta (based on autopsy report). Additionally, he opined that the degree of simple coal workers' pneumoconiosis was not severe enough to cause pulmonary disability or prevent him from working. Dr. Caffrey disagreed with a diagnosis of pulmonary hypertension and Dr. Rasmussen's diagnosis of cor pulmonale, based upon a normal echocardiogram. Overall, Dr. Caffrey opined that Mr. Vandall's 30 years of coal mine employment did not cause, contribute to, or hasten his death. Dr. Caffrey prepared another report in response to Dr. Perper's report which analyzed Dr. Caffrey's initial diagnosis of Mr. Vandall. Based upon his previous review of Mr. Vandall's medical data and Dr. Perper's report, Dr. Caffrey remained of the opinion that Mr. Vandall suffered from coal workers' pneumoconiosis and centrilobular emphysema (due to cigarette smoking and coal workers' pneumoconiosis to a minor extent). Further, he reiterated that neither of these conditions was severe enough to be disabling or to hasten Mr. Vandall's death. On July 30, 2004, Dr. Caffrey prepared a supplementary report to his previous report. EX 10. He reviewed additional medical evidence of Mr. Vandall. Dr. Caffrey held to his original opinion stated above and further stated that "Mr. Vandall's heart disease was not caused by his employment in the coal mine industry."

Dr. Bush

Dr. Stephen T. Bush reviewed Mr. Vandall's medical records on behalf of the Employer and provided a report dated January 13, 2003. EX 2. Dr. Bush is Board-certified in Anatomic and Clinical Pathology and Medical Microbiology. In this report, he reviewed Dr. Perper's report dated November 22, 2002, and Mr. Vandall's medical data previously provided to him. Dr. Bush opined that Mr. Vandall was not suffering with cor pulmonale. His overall opinion was

in accord with Dr. Caffrey's opinion, which was that Mr. Vandall was suffering from simple coal workers' pneumoconiosis, but this condition was not severe enough to have contributed to Mr. Vandall's death. On July 31, 2004, Dr. Bush prepared a supplementary report to his January 13, 2003 report. EX 8. This report reviewed additional medical data on Mr. Vandall. Dr. Bush disagreed with the opinions of Drs. Rasmussen, Koenig and Perper and opined that "anatomical evidence for a causal relationship between coal dust exposure and centrilobular emphysema in the absence of pneumoconiosis does not exist."

Other Medical Opinions Given in Connection with the Black Lung Claims

Dr. Salon

Dr. I.F. Salon examined Mr. Vandall on behalf of the Department of Labor on November 28, 1979. DX 71-18. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that Mr. Vandall worked in the mines for 20 years. The chest examination was normal. Dr. Salon read the x-ray as showing pneumoconiosis. Dr. Salon diagnosed pneumoconiosis and chronic obstructive pulmonary disease, which he opined was related to Mr. Vandall's coal dust exposure. He said Mr. Vandall's disease should not interfere with performing his usual activities.

Dr. Piccirillo

Dr. R.E. Piccirillo examined Mr. Vandall on behalf of the Employer on September 19, 1980. DX 70-11. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that Mr. Vandall had approximately 27 years of coal mine employment. The chest examination was normal. Dr. Piccirillo read the x-ray as showing no pneumoconiosis (0/1). Additionally, he opined that Mr. Vandall had no significant pulmonary impairment.

Dr. Diaz

As noted above, Dr. Diaz examined Mr. Vandall on behalf of the Department of Labor on March 14, 1986. DX 71-19. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that Mr. Vandall worked in the mines for at least 22 years. He reported that Mr. Vandall never smoked. The chest examination was normal. Dr. Diaz read the x-ray as showing pneumoconiosis (1/0). Dr. Diaz diagnosed pneumoconiosis and moderate emphysema. The report does not contain an opinion on the extent of impairment or disability.

West Virginia Occupational Pneumoconiosis Board

Drs. Walker, Revercomb, and Kugel signed a medical report on behalf of the West Virginia Occupational Pneumoconiosis Board dated January 13, 1987, after an examination of Mr. Vandall. Based on x-rays and physical examination, they could not make a diagnosis of occupational pneumoconiosis. DX 35; DX 71-40. The physical examination revealed an

increased AP diameter of the chest and rales in both lungs. There was no documentation, other than pulmonary function test results, accompanying this report.

Dr. Bembalker

As noted above, Mr. Vandall's Death Certificate was signed by Dr. Bembalker. In response to an inquiry from the Department of Labor, Dr. Bembalker marked responses that the autopsy revealed the deceased Miner did not have massive fibrosis or complicated pneumoconiosis, but did have simple pneumoconiosis; that pneumoconiosis was a substantially contributing cause or factor leading to the Miner's death; and, that death was caused by complications of pneumoconiosis. He did not provide a narrative report. DX 140.

Dr. Rasmussen

As noted above, Dr. Rasmussen performed an examination of Mr. Vandall on behalf of the Department of Labor on August 17, 1992. DX 12. During this examination, he took Mr. Vandall's medical, social, and family histories, and performed physical examinations, chest x-rays, pulmonary function studies, electrocardiograms, and arterial blood gas studies. Dr. Rasmussen noted that Mr. Vandall had 20 years of coal mine employment. He marked the box "never smoked" on the Department of Labor form. He read the x-ray as positive for pneumoconiosis, 1/1. The pulmonary function study demonstrated a severe, partially reversible obstructive ventilatory impairment. The arterial blood gas study showed marked impairment in oxygen transfer and hypoxia during exercise. Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on 20 years employment in coal mining and a positive x-ray, severe chronic obstructive pulmonary disease due to coal mine dust exposure, possible bronchospastic disease of undetermined origin based on significant reversibility of airway obstruction, and arteriosclerotic heart disease, a nonoccupational factor. He said that Mr. Vandall was totally disabled for resuming his former coal mine employment as result of severe pulmonary insufficiency. He thought there were significant parenchymal changes based on reduced diffusing capacity and gas exchange impairment during exercise. He said that coal mine dust exposure was the predominant cause of Mr. Vandall's pulmonary insufficiency, although he may have had an additional component of bronchospastic disease or hyperactive airway disease which was not the major cause of the insufficiency.

Dr. Rasmussen prepared narrative reports dated December 24, 1993 (DX 37), and February 22, 1994 (DX 42), which were introduced into evidence at the 1994 hearing. In the reports, he responded to medical evidence submitted on behalf of the Employer described below.

In the first report (DX 37), he noted the general consensus that Mr. Vandall had a severe pulmonary impairment rendering him totally disabled from resuming his former coal mine employment. He noted that epidemiologic studies among coal miners showed that chronic exposure to coal mine dust may cause chronic obstructive disease even absent x-ray evidence of pneumoconiosis. He said Mr. Vandall's emphysema was attributable to coal mine dust, as he was a nonsmoker. He also noted that there was evidence of hyperactive airways disease, which might increase Mr. Vandall's susceptibility to adverse effects of both cigarette smoke and occupational dust.

For the second report (DX 42), he had reviewed additional medical reports submitted by the Employer. Dr. Rasmussen agreed that Mr. Vandall had evidence of hyperactive airways disease, but said that the presence of asthma did not imply that coal dust exposure had not produced significant and disabling lung damage. He said there was also evidence of parenchymal lung tissue destruction, reflected by the reduced diffusing capacity and significant impairment in oxygen transfer during exercise, out of proportion to the degree of obstruction. He believed the parenchymal destruction could be due to emphysema. He disputed the suggestion that coal dust could not produce chronic obstructive lung disease and emphysema. He affirmed his belief that Mr. Vandall had a minimal smoking history in the 1950's, having interviewed him carefully concerning this. In addition, he stated, "[c]oal mine dust exposure and cigarette smoking are additive and not exclusive, and even the presence of significant cigarette smoking, in an individual, does not imply immunity to the adverse effects of coal mine dust exposure." He called coal mine dust a "major contributing factor to his totally disabling respiratory insufficiency."

Dr. Rasmussen also prepared an additional report after Mr. Vandall's death. The Claimant did not offer that report into evidence in the Miner's claim.

Dr. Koenig

Dr. Steven M. Koenig reviewed Mr. Vandall's medical records on several occasions on behalf of the Claimant, and provided reports dated January 7, 2000 (DX 98), February 26, 2000 (DX 110), and July 19, 2004 (CX 1). Dr. Koenig is Board certified in Internal Medicine, Critical Care Medicine, and Pulmonary Diseases. He reported that Mr. Vandall had 20 to 30 years of coal mine employment. He characterized Mr. Vandall's smoking history as "minimal." Dr. Koenig opined that Mr. Vandall suffered from "COPD, which includes chronic bronchitis and emphysema" and that coal dust exposure alone "is the primary if not the sole cause of Mr. Vandall's COPD and consequent respiratory impairment and total and permanent disability." Additionally, he opined that cigarette smoking may have contributed to Mr. Vandall's COPD, but said it was not the primary cause, and Mr. Vandall's smoking history was not sufficient to cause severe airflow obstruction. Additionally, Dr. Koenig found that Mr. Vandall's "coal dust induced COPD" was severe enough to make Mr. Vandall totally disabled from performing his last coal mine job and contributed substantially to his death. Dr. Koenig challenged the basis for diagnosing asthma, but said even if asthma was present, coal dust-induced COPD alone was of sufficient severity to render Mr. Vandall totally and permanently disabled from performing his last job in the mines, and to contribute to his death. He said the findings of pulmonary hypertension and right ventricular hypertrophy by Drs. Quadri, Tomashefski, and Perper supported the diagnosis of cor pulmonale, but said even without cor pulmonale, Mr. Vandall's COPD was of sufficient severity to render him disabled and contribute to his death.

Dr. Zaldivar

Dr. George L. Zaldivar examined Mr. Vandall and reviewed his medical data on several occasions on behalf of the Employer, and prepared reports dated February 6, 1989 (DX 71-44), February 15, 1989 (DX 71-38), August 31, 1993 (DX 31), January 12, 1994 (DX 39), March 1,

1994 (DX 44), September 8, 1999 (DX 81), January 4, 2000 (DX 95), January 17, 2000 (DX 102), and May 18, 2004 (EX 5). On January 25, 1989, and July 21, 1999, Dr. Zaldivar examined Mr. Vandall. DX 71-44; DX 71-38; DX 81. Dr. Zaldivar is Board-certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, and is a B reader. Dr. Zaldivar noted that Mr. Vandall had 25 years of coal mine employment, and 22 years of smoking. It appears that he did not credit Mr. Vandall's reports that he quit smoking in 1958, based on a contradictory note in one of Dr. Rasmussen's reports. The chest examination was normal. Based upon his review of the medical data and the physical examination, Dr. Zaldivar opined that Mr. Vandall did not suffer from pneumoconiosis, but did suffer with a severe respiratory impairment due to asthma, unrelated to coal mine employment or coal dust exposure. He said that Mr. Vandall's emphysema was due to smoking, not to coal dust. He also said that smoking can have a greater effect on persons with asthma. Dr. Zaldivar was deposed on March 16, 1990, and January 10, 2000, concerning his evaluation of Mr. Vandall. DX 31; DX 100. He reiterated his opinions given in his reports. Asked about Mr. Vandall's smoking history, he said Mr. Vandall told him he began smoking as age 19 and quit in 1956, for a total of six or seven years, which is not a significant smoking history. He reviewed additional x-rays and a CT scan during his deposition, all of which he found to be negative for pneumoconiosis. He attributed Mr. Vandall's reversible obstructive impairment to asthma and smoking. He said tests by Dr. Rasmussen in 1998 indicated severe impairment and total disability.

Later, however, in his May 18, 2004, report, after reviewing newly submitted pathological evidence, Dr. Zaldivar opined that Mr. Vandall did have pneumoconiosis. EX 5. He also found that Mr. Vandall had a respiratory impairment but that Mr. Vandall's respiratory impairment was not related in any way to coal mine dust exposure. Additionally, Dr. Zaldivar opined that Mr. Vandall was not able to perform his usual coal mining work, but that his coal dust exposure played no role in this disability. Furthermore, he opined that Mr. Vandall's pneumoconiosis was not strong enough to neither produce a pulmonary impairment nor hasten his death. On July 26, 2004, Dr. Zaldivar provided a supplementary report to his May 18, 2004, report in which he responded to criticisms by Dr. Rasmussen. EX 13. Dr. Zaldivar reiterated his opinions given in his previous report.

Dr. Fino

Dr. Gregory J. Fino reviewed Mr. Vandall's medical data on several occasions and prepared reports dated April 23, 1990 (DX 71-45), October 6, 1993 (DX 35), March 9, 1994 (DX 44), October 13, 1999 (DX 86), November 23, 1999 (DX 90), January 4, 2000 (DX 94), and January 17, 2000 (DX 102). At a deposition held on January 10, 1994, Dr. Fino testified about his evaluation of Mr. Vandall's condition. DX 39. He reiterated his opinions stated in his previous reports. Dr. Fino is Board-certified in Internal Medicine and Pulmonary Disease, and is a B reader. DX 86. Based upon his reviews, Dr. Fino opined that Mr. Vandall did not suffer from pneumoconiosis or an occupationally acquired pulmonary condition. Additionally, Dr. Fino opined that Mr. Vandall did suffer from a disabling respiratory impairment due to smoking and asthma, and was totally disabled from returning to his last coal mine job or job of similar effort. He said the medical literature did not support the conclusion that coal mine dust causes clinically significant obstructive disease absent significant fibrosis. Specifically, he opined that "this man's coal dust exposure played no role in his disability. Even if I assume that he has medical or legal pneumoconiosis, it has not contributed to his disability."

Dr. Dahhan

Dr. A. Dahhan reviewed Mr. Vandall's medical data on several occasions and prepared reports dated September 23, 1993 (DX 34), January 3, 1994 (DX 38; DX 39), March 1, 1994 (DX 44), September 24, 1999 (DX 84), November 11, 1999 (DX 89), December 29, 1999 (DX 95), January 13, 2000 (DX 102), and May 22, 2004 (EX 6). He is Board-certified in Internal and Pulmonary Medicine, and is a B reader. DX 84. Dr. Dahhan found that Mr. Vandall had 25 years of coal mine employment. Based on his reviews of the records before Mr. Vandall's death, Dr. Dahhan opined that Mr. Vandall suffered from a disabling obstructive impairment (chronic bronchitis and emphysema), had no evidence of pneumoconiosis or cor pulmonale, and suffered from total and permanent pulmonary disability not due to coal dust exposure or coal workers' pneumoconiosis. Dr. Dahhan did not accept that a disabling obstructive defect could be caused by coal dust. After Mr. Vandall's death, in his May 22, 2004, report, Dr. Dahhan diagnosed simple pneumoconiosis based upon his review of new pathological (autopsy) data. Dr. Dahhan was still of the opinion that, like his disability, "Mr. Vandall's death was not caused by, related to, contributed to or aggravated by his simple coal workers' pneumoconiosis or the inhalation of coal dust."

Dr. Chillag

Dr. Shawn A. Chillag reviewed Mr. Vandall's medical data on several occasions and prepared reports on October 7, 1993 (DX 35), December 30, 1993 (DX 38), March 4, 1994 (DX 44), September 23, 1999 (DX 85), November 10, 1999 (DX 88), and December 28, 1999 (DX 93). Dr. Chillag is Board-certified in Internal Medicine. DX 85. Deferring to the expertise of the sources relied upon by Dr. Fino (*see* DX 44), Dr. Chillag opined that Mr. Vandall did not suffer from pneumoconiosis. Additionally, Dr. Chillag found that Mr. Vandall suffered from a disabling pulmonary impairment not attributable to pneumoconiosis, asthmatic in origin, and possibly related to cigarette smoking. He said Mr. Vandall's disability was not due to pneumoconiosis, because it was "not the type of impairment seen with pneumoconiosis." He also characterized Mr. Vandall's smoking history as variable, implying that he did not credit that smoking ceased in 1958.

Dr. Castle

Dr. James R. Castle reviewed Mr. Vandall's medical data on several occasions and prepared reports dated November 1, 1999 (DX 88), November 30, 1999 (DX 91), January 5, 2000 (DX 94), and January 26, 2000 (DX 103). Dr. Castle is Board-certified in Internal Medicine and Pulmonary Diseases, and is a B reader. Based on his review of the records, Dr. Castle opined that Mr. Vandall did not suffer from pneumoconiosis, but did suffer from severe reversible airway obstruction. Additionally, Dr. Castle found that Mr. Vandall was totally and permanently disabled from a pulmonary perspective, but said that this disability was not due to pneumoconiosis. He opined that the total disability was related to bronchial asthma and pulmonary emphysema due to tobacco abuse. On January 17, 2000, Dr. Castle was deposed concerning his evaluation of Mr. Vandall's medical condition. DX 101. Dr. Castle had reviewed additional materials, including x-rays and a CT scan. He did not see evidence of either

emphysema or pneumoconiosis. He said Mr. Vandall had a disabling respiratory impairment based upon obstructive airway disease which was significantly reversible, and hypoxemia which developed with exercise. He did not find evidence to substantiate a diagnosis of cor pulmonale. He believed the disability to be due to airways remodeling due to insufficiently treated asthma, and smoking, but not due to exposure to coal mine dust. He believed Mr. Vandall smoked for 22 years. In his 1999 report, DX 91, Dr. Castle stated, "[w]hen coal workers' pneumoconiosis causes clinically significant impairment it does so by causing a *mixed, irreversible obstructive and restrictive* ventilatory impairment." He attributed Mr. Vandall's obstructive disease with reduced diffusing capacity entirely to smoking-induced emphysema.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). The record in this case contains numerous readings of many x-rays taken between 1973 and 1999. The weight of the x-ray evidence is negative. As the autopsy evidence conclusively establishes that Mr. Vandall had pneumoconiosis, the negative x-ray evidence is of little significance.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The file contains several readings of a CT scan taken on November 2, 1999. All were negative. Like the negative x-ray evidence, these readings are of little significance given the results of the autopsy.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005).

The Employer stipulated at the previous hearing that Mr. Vandall was totally disabled from a pulmonary disability. DX 106 at 7. The CM-1025 listed total disability as being at issue in the request for modification. However, the Employer offered no evidence on this issue into the record at the most recent hearing. In any event, all of the pulmonary function tests have produced qualifying values since the test administered by Dr. Zaldivar on January 25, 1989, DX 71-38, 44. In addition, the exercise blood gas study administered on August 17, 1992, DX 13, resulted in qualifying values, as have all of the studies at rest since January 15, 1997. Moreover, since Dr. Zaldivar's examination in 1989, all of the physicians who examined Mr. Vandall or reviewed his medical records and offered an opinion on total disability agreed he was totally disabled. The evidence of disability is sufficiently compelling that I need not address the dispute among the doctors whether Mr. Vandall also had cor pulmonale.

I find that Mr. Vandall was totally disabled from at least January 25, 1989, to the end of his life.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, the Claimant's medical records indicate that he has been diagnosed with coal workers' pneumoconiosis, as well as chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply because the evidence does not establish the existence of complicated pneumoconiosis, and the Miner filed his claim after January 1, 1982, and died after March 1, 1978. The autopsy conclusively establishes the presence of clinical pneumoconiosis, as every doctor who has seen the results agrees. Hence I give no weight to the negative x-ray and CT scan readings. In order to determine whether the evidence also establishes the existence of legal pneumoconiosis, I must consider the medical opinions, including the treatment records, the Pathologists' opinions, and the other opinions offered in connection with the black lung claims.

The Claimant can establish that Mr. Vandall suffered from legal pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986).

In determining whether legal pneumoconiosis exists in this case, I must also consider the holding of the United States Court of Appeals for the Fourth Circuit in *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995), that "chronic obstructive lung disease … is encompassed within the definition of pneumoconiosis for the purpose of entitlement to Black Lung benefits." 60 F.3d at 175. The Court found that the assumptions of physicians that obstructive disorders

cannot be caused by coal mine employment or that a diagnosis of pneumoconiosis cannot be made without x-ray or tissue samples to be erroneous. Citing *Eagle v. Armco, Inc*., 943 F.2d 509 (4th Cir. 1991), the Court noted that "the opinion of an expert 'that breathing coal mine dust does not cause chronic obstructive lung disease … must be considered bizarre in view of [ ] Congress' explicit finding to the contrary.'" 60 F.3d at 174-175 (citations omitted). The Department's position underlying the amended regulations is that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. Citing to studies conducted by NIOSH, the Department quotes the following from the NIOSH summary:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present.…

65 Fed. Reg. at 79943. The Department then states, "[t]hat coal mine dust exposure can cause obstructive lung disease is now a well-documented fact." *Ibid*. The Department goes on to observe that this position "is consistent with the growing body of case law recognizing that obstructive lung diseases can arise from coal mine dust exposure." *Ibid*. (citations omitted). In this case, the physicians relied upon most heavily by the Employer (the Pathologists, Drs. Tomashefski, Oesterling, and Bush, and the Pulmonologists, Drs. Zaldivar, Fino, Dahhan, Chillag, and Castle) all expressed the "bizarre" view that coal dust exposure does not cause obstructive lung disease. In adopting the amendments to the regulations, the Department specifically rejected the contrary opinions expressed by Dr. Fino, as well as his critique of the scientific literature. *See* 65 Fed. Reg. at 79938-79943, *passim*.

In addition to the fallacy that coal dust does not cause chronic obstructive pulmonary disease, the opinions relied upon by the Employer posit a much longer smoking history (up to 22 years) than I have found. Their reliance on an exaggerated smoking history undermines the conclusions they reached. Moreover, even were I to agree with them that the record supported a finding of 22 years of smoking, at half a pack a day, that only amounts to 11 pack years, ceasing in 1973, nine years before Mr. Vandall left the mines. None have addressed the fact that Mr. Vandall ceased smoking many years before he stopped mining. None of the Employer's physicians have offered any convincing explanation why coal dust should be eliminated as a cause of Mr. Vandall's emphysema, even if he smoked as much as they thought. Their failure to do so, coupled with their complete dismissal of any effects from pneumoconiosis, leads me to the conclusion that their opinions are less than objective. Even Dr. Caffrey, who at least acknowledged that pneumoconiosis could have contributed to Mr. Vandall's emphysema "to a minor extent," failed to address the fact that he was exposed to coal dust for many years after he stopped smoking. Nor does the fact that Mr. Vandall had reactive airways disease or asthma exclude exposure to coal dust as a significant contributing factor in Mr. Vandall's lung disease.

All of the physicians consulted by the parties, Pulmonologists and pathologists, possess excellent credentials. Nonetheless, I find that the opinions offered by Drs. Zaldivar, Fino, Dahhan, Castle, Chillag, Tomashefski, Bush, Caffrey, and Oesterling are entitled to less weight, as they are inconsistent with the premise underlying the statute and regulations, that exposure to coal dust can cause chronic obstructive air disease; they relied upon an exaggerated smoking

history; and they failed to offer any credible reason for ruling out coal dust exposure as a contributing cause for Mr. Vandall's chronic obstructive pulmonary disease along with any other contributing factors. Their credibility is also undermined by the fact that none diagnosed even clinical pneumoconiosis during Mr. Vandall's lifetime; by way of contrast, the autopsy results confirmed Dr. Rasmussen's opinions. I give greater weight to the opinions of Dr. Rasmussen, Mr. Vandall's treating physician for over seven years, supported by the opinions of Dr. Quadri, Dr. Perper, and Dr. Koenig, as well as the Death Certificate and questionnaire response by Dr. Bembalker, all of which are better supported by the evidence as a whole.

I find that the Claimant has shown that Mr. Vandall had both clinical and legal pneumoconiosis. It follows that the Judges who heard this claim previously made a mistake of fact when they ruled that he did not have pneumoconiosis. It also follows that the Claimant has established a change in conditions since the prior claim was denied, as the Judge who ruled on Mr. Vandall's prior claim also ruled that he had failed to show that he had pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). Mr. Vandall was employed as a miner for at least 25 years, and therefore, is entitled to the presumption.[2] The Employer has not offered evidence sufficient to rebut the presumption. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis was a "substantially contributing cause" to the miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2005); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990).

The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in

[2] The Tenth Circuit recently held that the presumption does not apply to legal, as opposed to clinical, pneumoconiosis. *Anderson v. Director, OWCP*, ___ F3d ___ (10th Cir. No. 05-9550, July 25, 2006). In proving legal pneumoconiosis, however, the Claimant has established that Mr. Vandall's chronic obstructive pulmonary disease was caused by exposure to coal dust, by means of the medical opinions which I have credited. Thus, she has established causation of legal pneumoconiosis without reference to the presumption.

point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also, Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002). In this case, all of the Pulmonologists who have seen Mr. Vandall's medical records since 1989 agreed that he was disabled by a severe pulmonary impairment. Despite a minimal smoking history, or at least one which ended years before his exposure to coal dust ended, none of the doctors relied upon by the Employer diagnosed clinical or legal pneumoconiosis until compelled to do so by the autopsy. Even then, they continued to blame the Claimant's disabling obstructive pulmonary disease on his cigarette smoking, or asthma, but entirely discounted his exposure to coal dust. None have provided any credible, persuasive reasons for concluding that pneumoconiosis did not contribute to his disability. In essence, the doctors relied upon by the Employer found clinical, but not legal pneumoconiosis, as a result of which, their opinions are entitled to little weight. Again, Dr. Rasmussen's opinion, supported by those of Dr. Koenig and Dr. Perper, that coal dust significantly contributed to Mr. Vandall's disability, is consistent with the medical evidence as a whole, and entitled to great weight.

I find that the Claimant has established that Mr. Vandall was totally disabled due to pneumoconiosis.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2005); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

Mr. Vandall filed his current claim for benefits in July 1992. When he was examined by Dr. Zaldivar in 1989, he was already totally disabled. The current regulation regarding subsequent claims provides that "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5) (2005). Although this rule is not applicable to the Miner's claim (*see* 20 CFR § 725.2 (2005)), it was intended to effectuate the ruling of the 4th Circuit in *Lisa Lee Mines*, 86 F.3d at 1362, that in a subsequent claim, the final decision on

the prior claim must be accepted as correct. *See* 65 Fed. Reg. at 79968. Applying that principle to this case, the Administrative Law Judge issued his Decision and Order on Mr. Vandall's prior claim on August 3, 1990. As Mr. Vandall took no further action on that claim, it became final one year later, on August 3, 1991.

I find that the Miner was entitled to benefits commencing in August 1991, the month the decision on his prior claim became final..

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that Mr. Vandall had pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus, the Claimant has met her burden of showing that a mistake of fact was made in the prior denial of Mr. Vandall's pending claim, and that there was a material change in conditions since denial of his previous claim. Accordingly, Mr. Vandall was entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, .365 and .366 (2005). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A Service Sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The request for modification filed by Doris Vandall on behalf of Amos Vandall on April 10, 2001, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS**: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail

and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).